PHP32
GEOGRAPHIC VARIATION IN MEDICARE PART D PLAN ENROLLMENT, PREMIUMS, COPAYMENT, AND COINSURANCE
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OBJECTIVES: Medicare Part D represents the single most significant expansion of a public insurance program in 40 years. The program provides drug coverage through multiple private insurance plans. A key question is whether Medicare beneficiaries choose plans based on expected premiums and out-of-pocket costs. Studies show that about 72% of seniors consider the amount charged for each prescription as an important factor in deciding on drug plan enrollment. Yet, few studies have explored the extent to which potential differences exist based on service region. The objectives of this study were to: 1) examine differences in Medicare Part D premiums, copay and coinsurance by geographic region, and 2) determine whether lower premiums, copay and coinsurance were primary drivers for enrollee decision making in selection of plans. **METHODS:** A retrospective study design was employed using data obtained from the Centers for Medicare and Medicaid Services. The data was entered into SPSS 18.0 and descriptive and inferential statistics were utilized to examine differences. **RESULTS:** A total of 17 million enrollees constituted the study sample. Across all regions Medicare Part D plans utilized fixed-dollar copays more often than coinsurance for generic and brand name drugs. The average premium for Northeastern, Midwestern, Southern and Western region enrollees was $34, $37, $35 and $33, respectively ($p<0.05$). Furthermore, the average copay/coinsurance for Northeastern, Midwestern, Southern and Western enrollees was $15/5%; $14/5%; $13/6% and $14/6%, respectively ($p<.05$). Overall, the most popular benefit designs, chosen by 75% of enrollees, offered a premium of $39, a copay of $33 and a coinsurance of 25%. **CONCLUSIONS:** Findings of this study suggest that seniors may not always choose the plan with the lowest cost sharing. Premiums of $20, copays of $25 and coinsurance rates of 15% have been reported in the literature as ideal. Factors other than savings may drive Part D plan enrollment decisions.

PHP34
ELICITING PREFERENCES FOR REIMBURSED DRUGS SELECTION CRITERIA IN COTE D'IVOIRE
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OBJECTIVES: Côte d'Ivoire, a West African country, has decided to set up a formulary as part of its universal health insurance (UHI) program. One of its goals will be to facilitate access to safe and efficacious drugs. To guarantee transparency throughout the formulary listing process, it is important to select and value relevant decision criteria for that purpose. Thus, the objective of this study was to investigate the preferences of healthcare professionals (physicians) when selecting reimbursable drugs and to analyze trade-offs between criteria for formulary listing in Côte d'Ivoire. **METHODS:** Choice sets based on four attributes (cost effectiveness of treatments, severity of the disease for which the treatments are indicated, age of the population affected by diseases considered, and social class affected by diseases considered [poor, rich]) were presented in a self-completion questionnaire. **RESULTS:** Analysis of questionnaire responses showed that 'cost effectiveness', 'severity of disease', and 'social class' were significant attributes in responder's preferences for reimbursable drugs. More specifically, respondents' choices were more sensitive to drugs that are very cost effective, that target very severe disease, and that target diseases in poor people. **CONCLUSIONS:** This explorative study enabled us to elicit the preferences of a sample of healthcare professionals (physicians) for reimbursed drug selection criteria in Côte d'Ivoire using the discrete-choice experiment method. Further work is required to achieve the ultimate objective of developing a formulary for Côte d'Ivoire.

HEALTH CARE USE & POLICY STUDIES – Health Care Costs & Management

PHP35
DETERMINANTS OF PARTICIPATION IN MAMMOGRAPHY SCREENING IN TAIWAN
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OBJECTIVES: Mammography screening has been considered as an effective way for early detection of breast cancer to reduce the mortality of breast cancer. In Taiwan, mammography screening has been offered biennially free for woman aged 50-69 years since July 1, 2004. Nevertheless, the participation rate of mammography screening was quite low among women eligible for this benefit, and factors that influence beneficiaries' decision on participation remained unknown. Thus, the study aimed to examine major determinants associated with participation in mammography screening among eligible women in Taiwan. **METHODS:** The Taiwan Longitudinal Health Insurance Dataset of 2005 was conducted for the study. Women aged 50-69 years on July 1, 2004 or going to be aged 50 years during July 1, 2004 to December 31, 2009 were identified as study subjects. Age, socio-demographic characteristics, previous experience of Pap test, health-related conditions were analyzed to evaluate the association with the likelihood of participation in mammography screening using Cox proportional hazard model. **RESULTS:** There were 106,760 beneficiaries during the observation period. Women who were with higher wage income level, being employed, receiving Pap test in last two years, with *history* of benign *breast* disease, and having higher Charlson Comorbidity Index score were significantly more likely to participate in mammography screening. Women who were older, with breast cancer history, and residing southern part of Taiwan were significantly less likely to participate in mammography screening. **CONCLUSIONS:** Age, socio-demographic characteristics, experience of Pap test and health-related conditions seemed to be determinants of participation in mammography screening. Trends in participation in mammography screening by determinants need to be evaluated in the future for policy makers to address the low participation rate of mammography screening among beneficiaries.

PHP36
COMPREHENSIVE VALUE ESTIMATION OF ADALIMUMAB-BASED TREATMENTS: COVET STUDY
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BACKGROUND: The value of a drug can be expressed as the needed cost to increase a health unit. An estimation of an index that summarize the value of a molecule with multi-indication, however, is a complex process. **OBJECTIVES:** Covet study had the specific objective of a comprehensive economic evaluation of adalimumab. **METHODS:** An Econometric algorithm has been developed to estimate the total economic value of Adalimumab. This value was calculated as the sum of the cost per QALY gained in the treatment of rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease and psoriasis. The sum was weighted by prevalence data for each of the diseases considered. Boston Matrix has been developed to establish the relationship between demand (prevalence of the disease) and health supply (e.g. the willingness to pay - WTP - of the health care authorities). Finally, a League Table has been built in order to compare the cost-effectiveness of Adalimumab with other innovative molecules. A sensitivity analysis based on the variability of Economic Evaluation model of Adalimumab has been performed. **RESULTS:** The total economic value of Adalimumab in Italy amounted to €27,700. The sensitivity analysis showed a cost per QALY gained ranging between €19,487 and €32,453. The analysis of the Boston matrix, developed for each pathology, indicates that the cost per QALY gained of Adalimumab was generally below the common WTP with the exception of psoriasis (€52,600). **CONCLUSIONS:** The study provides a first indication of the total economic value of Adalimumab, that is below the threshold value for health care interventions for all the main pathologies treated with this molecule. Results of the study are helpful for decision makers, who should ensure that patients have equal access to a cost-effective treatment, as well as promote research and development of innovative molecules with greater cost-effectiveness ratio.

PHP37
ARE HOSPITAL INPATIENT COSTS LOWER FOR MEDICARE ADVANTAGE ENROLLEES THAN MEDICARE FEE-FOR-SERVICE BENEFICIARIES?
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OBJECTIVES: This paper compares the private health plans that enroll Medicare beneficiaries—known as Medicare Advantage (MA) plans— in cost to the traditional Medicare fee-for-service (FFS) program by employing a series of methodological approaches based on propensity score matching to address the moral hazard and adverse selection issues. **METHODS:** The Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) were used in this analysis. We use hospital inpatient data for 2008 and 2009 from California, Florida, Massachusetts, New York, Tennessee and Wisconsin. The SID provide detailed diagnoses and procedures, total charges and patient demographics for all participating states. Our key covariate of interest is MA enrollment and the total costs associated with each hospital visit. To obtain costs, we applied hospital specific HCUP cost-to-charge ratios. We adjusted these costs with the CMS area wage index. We obtained information about hospital characteristics using the American Hospital Association Annual Survey Database; and county level information from the Area Resource File. We estimate a baseline risk-adjusted cost model to compare the total health care costs two cohorts in inpatient settings. To assess the robustness of our baseline results, we re-estimated our risk-adjusted cost model following various propensity score matching methods. **RESULTS:** Inpatient cost for MA enrollees was generally lower than the inpatient cost for Medicare FFS beneficiaries when moral hazard and adverse selection was controlled. For example, our estimate shows that the total health care costs per inpatient visit for MA enrollees are higher by 2.6% in Florida, and lower by 12.6% in California when compared to Medicare FFS. We also observed the prevalence of many chronic conditions among MA enrollees was generally lower than among Medicare FFS beneficiaries. **CONCLUSIONS:** We found wide geographic variations in hospital inpatient costs, and in prevalence of chronic conditions between MA enrollees and Medicare FFS beneficiaries.

PHP38
OUT-OF-POCKET DRUG EXPENDITURE AMONG USERS OF THE AMBULATORY CARE SERVICES AT THE MEXICAN INSTITUTE OF SOCIAL SECURITY (IMSS)
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OBJECTIVES: The aim of this study is to quantify out-of-pocket drug expenditure among ambulatory care users and to identify the variables associated with the payment for medicines during 2010 at the Mexican Institute of Social Security. **METHODS:** Data from the institutional health survey 2010 was used to estimate the total and mean drug out-of-pocket expenditure among ambulatory care users. Statistical analysis was performed to test for mean expenditure differences by age and gender. A binary logistic regression model was constructed to identify the main factors related to payment for prescribed medicine. Data was aggregated according to the marginality index estimated by the Mexican National Council of Population to consider socio-economic regional variations. The exchange rate was $12.34 pesos per dollar. **RESULTS:** A total of 71.9% of the health care users received